Therapy with Families with Chronic Medical Issues

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Twenty-first century health care for families challenged by chronic medical issues is likely delivered within a complex social system beyond that of one's immediate family. Formal and informal helpers adopt many roles and perform various functions in response to one or more family member's life-altering, and, perhaps, life-threatening medical condition. These partners in care serve two key functions. One function is that they help family members with a medical condition (patient/s) establish and maintain access to the latest advances in medical care, technology, and research. A second function is that they build caring, supportive relationships around the family to sustain compassionate healing environments. Nurturing contexts help families motivate the patient to adhere competently to an optimal plan of care while skillfully navigating the impact of their medical condition on the unremitting demands of life (National Research Council and Institute of Medicine, 2009). When the patient and his/her family cope effectively, collaborative relationships within their unique community of care seem to evolve naturally and respond flexibly to expected and unexpected demands imposed by the medical condition. Medical care takes center stage with psychosocial care coming to the fore as needed (Simms, 1995).

Research Informed Psychosocial Care in Medical Settings

Systemically dedicated mental health professionals work in the patient's and family

system's best interest (Wilcoxon, Remley, & Gladding, 2012). To do so, they must devise and put into action a theoretically coherent, therapeutically relevant, research informed treatment plan. These discrete, indispensable and interlocking parts are vital to implementing competent care (Zur, 2007). However, mental health professionals may consider this important challenge as a tall order to fill. Time sensitive, cost conscious, and stress ridden care settings may impede their efforts. The following case study illustrates how a mental health professional (second author, Linda Hawkins [LH]) successfully bypassed such systemic forces by adopting this treatment imperative when approaching a psychosocial challenge connected to a life threatening chronic medical issue in a complex medical setting.

Engaging Patients, Families, Communities, and Health Care Systems

Professional-as-expert model. As the accompanying literature review illustrates, it is common for worrisome behavioral, emotional, and/or mental symptoms to co-occur with chronic medical issues. When this happens, the delivery of psychosocial care, like medical care, is anchored in a professional-as-expert model (Blackall, Simms, & Green, 2009). Patients, family members, or health care professionals present concerns about symptoms to therapists who then accept responsibility for psychosocial care. The patient accepts the expert because he/she possesses the knowledge and skills to help them feel and function better. When this model works -- and it usually works well – it is gratifying to all involved. Many therapists and their related practice settings are anchored in this approach. The professional-as-expert model falters, however, when a professional, the patient, and/or their family persistently disagree on the underlying cause of the presenting concern and/or the best way to proceed (see Figure 8.1).

[Insert Figure 8.1 here]

Clinical impasses in medical settings. Conflict is common in medical settings (Studdert.

Burns, Mello, Puopolo, Truog, & Brennan, 2003). Disputes occur naturally within intimate connections like the doctor/nurse-patient/family relationship. Most people find ways to sidestep or resolve them. However, conflicts evolve into impasses in medical settings, when disagreements over symptom formation, treatment effectiveness, and symptom resolution refuse to go away and relationships deteriorate (Blackall, Simms, & Green, 2009; Meltzer, Steinmiller, Simms, Grossman, The Complex Care Team, & Li, 2009; Micucci, 2009). For example, enduring struggles over a physician's concern about noncompliance versus the patient's retort, "what's the point, it doesn't work", can provoke hurtful interpersonal withdrawal as evidenced by "no shows," requests for a new doctor, and the professional's insistence on a psychiatric referral. In stark contrast with the focus on managing symptoms as part of the professional-as-expert model, mental health professionals in these situations must first help those in conflict reconnect before addressing the presenting concern. Shifting from expert-driven fixes that lead to ruptures in critical relationships to focusing on collaboratively unraveling human puzzles paradoxically exposes unseen solutions.

Professional-as-collaborator model. Therapists responsible for psychosocial care in the context of relationships trapped in conflict confront a conundrum, not knowing who is the patient and where or what is the focus. Patients and/or their family members describe commonly feeling frightened, blamed, and/or abandoned by others when embroiled in these impasses. Health care professionals view themselves as typically responsible for helping but feel powerless to ameliorate the impact of psychosocial symptoms on medical treatment. Entering this context through the Professional-as-collaborator model enables mental health professionals to create a roadmap on how to go around these stalemates (Blackall et al., 2009). Therapists adhering to this model help patients, their families, and medical team members reconnect as partners. The

therapeutic focus is on building collaborative, solution-focused frameworks around and through psychosocial challenges (see Figure 8.2). Making the shift from patient-centered to relationship-centered care sets the stage for therapists to select and then employ a theoretically coherent, family-based treatment model, as the accompanying literature review recommends.

[Insert Figure 8.2 here]

Family Therapy Approaches to Chronic Medical Issues

Translating family science into therapy. How do mental health professionals attune to relevant research findings in every therapeutic situation? They follow three basic steps. First, they know the relevant literature. The accompanying literature review is a handy example of how a comprehensive review of the research can prepare therapists to face an array of chronic medical issues. Second, they cull and organize relevant practice related conclusions. Third, they distill these conclusions into a concise research informed practice checklist. See Gwande (2009) for an excellent discussion of the value of user developed checklists in research informed practice.

We studied then applied Gwande's (2009) recommendation to the accompanying literature review. In doing so, our effort generated eight key practice related conclusions for the mental health professional. These include:

1. Expect chronic medical issues and related psychosocial challenges to present in a all practice settings.
2. Expect chronic medical issues to be more common in minority populations; know how one's own values and cultural diversity impacts human development, acculturation, and clinical outcome (see Wilcoxon, Remley & Gladding, 2012).
3. Assess how family structure variables (e.g., two-parent family, single-parent low-income

family) help or hinder patient and family resilience and adaptation.

4. Determine if family process variables, in particular family cohesion, and caregiver alliances enhance or undermine effective family functioning.

5. Gauge the family's social connections, because connected families are likely more adaptive, whereas isolated families are likely less adaptive.

6. Determine the presence/absence of high, persistent family conflict, as high, persistent conflict undermines family functioning.

7. Evaluate social control strategies, as coercive strategies reduce adherence.

8. Use family-based interventions, because they are generally more effective than psycho-educational approaches.

These eight practice points can then be used to create a research informed psychosocial practice checklist for working with families with chronic medical issues. Such a checklist serves as a quick, simple, portable, unobtrusive ready reference to use before, during, and after patient care encounters.

Selecting a family therapy model. The accompanying literature review shows that chronic medical issues impact and are impacted by relationships; therefore, family-based interventions are the recommended standard of care. This relational perspective and treatment approach is rooted in family systems thinking. Therapists who work as systems thinkers view all of life's challenges as embedded in interpersonal patterns. These observable, predictable, recurring interpersonal patterns help or hinder a family's reactions to chronic medical issues. Systemically focused mental health professionals must perform three key activities: recognize the pattern binding the family and, sometimes, their partners in care; understand what the "new" pattern may look like; and respond in ways that help families and their partners create a new pattern (i.e.,

relate differently to one another around the conflict-laden medical challenges) (Blackall et al., 2009).

Nichols and Schwartz (2008) convincingly showed that therapists face a dazzling array of choices when considering and selecting techniques, concepts, and family therapy school(s) to apply to each case. To shape this vast resource into a doable family-based framework, our experience working with these families suggests that the therapist consider Simon's (2006) cogent approach to crafting a theoretically coherent, clinically relevant, research informed clinical framework. Here, the mental health professional determines what techniques, fundamental concepts, and family therapy school(s) best fit their personal belief system and world view. Philosophical congruence between personal and professional world views enables therapists to engender an *espirt de corps* with patients, their families, and members of larger care system. Communicating this deep felt commitment through competently implementing the selected therapy model helps therapists to earn and exert a well-received leadership role around their clinical perspective. Should the practice setting permit such clinical leeway, the mental health professional is encouraged to consider such a process in selecting a therapy model to approach psychosocial challenges related to chronic medical issues. The following description and application of Ecosystemic Structural Family Therapy (Lindbald-Goldberg & Northey, 2013) represents our efforts to do so.

Ecosystemic Structural Family Therapy (ESFT). ESFT is one of many viable clinical approaches for chronic medical issues. ESFT is a systems-based family therapy approach to working with patients, their families, and related social contexts (e.g., medical settings) when facing life altering and life threatening challenges (Lindblad-Goldberg, Jones, & Dore, 2005; Lindblad-Goldberg & Northey, 2013). ESFT evolved philosophically from Structural Family

Therapy (Minuchin, 1974), a model applied to and scientifically investigated around various psychosocial symptoms related to a host of chronic medical conditions, including diabetes/asthma/anorexia nervosa (Minuchin, Rosman, & Baker, 1978), gastrointestinal conditions (Wood, Watkins, Boyle, Nogueira, Zimand, & Carol, 1989), and survivorship in pediatric oncology (Kazak et al., 1999).

Consistent with its systemic roots, ESFT directs mental health professionals to three key activities. In one activity, the therapists must **see** how the family works. Severe symptoms suggest that the family is ensnared in a core negative interactional pattern (CNIP). This pattern shows how family members and, sometimes, members of their community of care, respond to one another in ways that erode effective individual and family functioning and inadvertently reinforce presenting concerns. The ensuing breakdown of the family's organization maintains symptomatic behavior and blocks individual and family adaptation. A second task for therapists is to **understand** how to forge a new interactional pattern with the family. New patterns are built around four targets of assessment and change (co-caregiver alliance, attachment, self-regulation, and executive functioning). The third and final task is for therapists to **respond** to family members in ways that provoke more flexible ways of thinking and behaving. In doing so, therapists conduct and traverse four distinct stages of therapy (join, reframe, enact, and anchor). The ESFT checklist (see Table 1) serves as a ready-reference for a basic description of the model.

Table 1. ESFT Checklist

<u>See</u> How the Family Works

- ✓ Diagram the CNIP.
- ✓ Include 3 people in every CNIP.
- ✓ Describe the CNIP in a language that captures family process, e.g., mother yells/IP threatens (symmetrical) and father enters/mother withdraws (complementary).

Understand How to Forge a New Interactional Pattern with the Family

- ✓ Diagram a new family pattern.
- ✓ Build new pattern on 4 targets of assessment/change:
  - o Bolster co-caregiver alliance(s). The successful co-caregiver alliance is the social support network that helps family executives build caring family contexts.
  - o Facilitate interpersonal connections (attachment). Safe and secure attachments are the building blocks of a nurturing family environment.
  - o Enhance self-regulation. Optimal self-regulation helps family leaders maintain a nurturing family environment.
  - o Build up parental executive skills. Effective executive functioning signifies that family leaders (individuals, caregivers, spouses, or partners) organize and then guide family members and their community of care to create a nurturing family environment.

Respond in Ways that Bring Out "New" Thoughts, Feelings, and Behaviors

- ✓ *Stage 1: Join* -- Help family members feel accepted, understand, appreciated, hopeful, and challenged.
- ✓ *Stage 2: Reframe* -- Use assessment data to help the family discover then rely on a new meaning of the presenting problem in developmental, relational, contextual trauma informed ways.
- ✓ *Stage 3: Enact* -- Create enactments to block the CNIP and forge new family patterns.
- ✓ *Stage 4: Anchor* -- Seek then secure community based connections that promote new patterns leading to optimum individual & family development.

Why do resilient families thrive and vulnerable families collapse in response to the tragedies of life such as chronic medical issues? Families that breakdown may be seen as a separate and unique culture in the clinical context. ESFT's basic components (see, understand, and respond) dovetail with the earlier described eight research-informed practice conclusions to offer an explanation of how and why vulnerable families crumple in response to life's challenges. The vulnerable family is probably led by a single, perhaps minority, and/or poverty-stricken adult who is likely female and also alone, isolated and cut off from supportive and nurturing relationships. This family's process is likely characterized by low cohesion and weak emotional ties coupled with a reactive style of emotional expression. This often leads to withdrawal (e.g., depression) or angry emotional escalations fueling long-lasting conflict and

interpersonal withdrawal. The family executive probably leads or parents with a harsh, coercive socialization and management style. Families plagued by a weak co-caregiver alliance, insecure attachments, poor self-regulation, and ineffective executive functioning are at risk to buckle then collapse when facing the demands of a chronic illness. The following case study offers an elaborated description and an empirically informed application of ESFT.

Case Study

Brief history and background. Nathan is a 20-year-old African American male recently diagnosed with Type 2 diabetes. He resides in an urban, east coast city with his grandmother and mother. His father lives in their community, but cut Nathan off when he came out as gay at age 14. In addition, Nathan was bullied in school for being quiet and awkward. In middle school, he was referred to a counselor who identified the presenting communication and social challenges as consistent with Asperger's disorder. This diagnostic description and subsequent treatment approach helped teachers and family members better understand and assist him in navigating his developmental challenges. Throughout his school years, Nathan's maternal grandmother assumed the position as primary caregiver. His mother is the family's sole breadwinner. Nathan has four older siblings living independently and at a distance from Nathan.

Culture, power, and privilege challenges. Generational poverty, extremely limited food stability in the community, chronic mistreatment as a racial minority child and youth, as well as the tragedy of parental rejection, took its toll on Nathan. His care team is led by a male Caucasian endocrinologist, a female Caucasian nurse practitioner, and a female Caucasian family therapist, Linda Hawkins (LH).

Medical team assessment. The medical team's assessment of Nathan and his family yielded two key conclusions. First, Nathan's mother was a single parent. Second, his father was

absent. Attuned to research findings suggesting poorer treatment outcomes for patients from single-parent homes, the medical team understandably wanted to strengthen his foundation of support to quickly implement his diabetes management protocol. To do so, they sought to secure his father's participation with the hope of creating a two-parent health care alliance. The nurse practitioner in charge of diabetes education invited Nathan's father to attend a class with Nathan and his mother. He was a "no show" twice, provoking cancellations of the class. Nathan and his mother responded with silence. The medical team was concerned about Nathan's withdrawal and "a family issue," so they asked LH to join the care team.

Stage 1: Join. ESFT directs therapists to join with the identified patient, their family, and crucial members of their broader ecosystem (e.g., medical care team). Here, therapists must accomplish three basic tasks: engage each participant through their appropriate hierarchical position in a developmentally expected way where relevant, discover the truth of each participant's distress, assuming that all behavior including symptomatic behavior is viewed as grounded in good intent and concern; and assign meaning (underlying significance) to the presenting symptoms and other concerns. Joining effectively means that the mental health professional garners each participant's acceptance and, more importantly, earns acceptance as the system's leader for change (Colapinto, 1991).

Working from the professional-as-expert position, the medical team unilaterally added LH to the care team. The presenting problem was framed as Nathan's depression, withdrawal, and a family-based concern. Because the team made the referral (not Nathan or his family), LH attempted first to join with the medical team around their stated concerns. They rebuffed this bid to connect by stating "everything you need to know is in the chart." Reviewing her research findings checklist, LH contemplated family risk factors (e.g., minority family, single mother,

possible low family cohesion, social isolation,high conflict), then reviewed the ESFT checklist, and determined to enter the patient-family-care team impasse through Nathan.

Guided by research indicating that family-based interventions tend to be more effective than psycho-educational approaches, LH connected with Nathan and then his mother around the three tasks of joining. Attuned to his developmental position as a young adult, she turned first to Nathan then to his mother. Building on his previous counseling experience, Nathan disclosed that his communication style and pace was slow and repetitive. When receiving information quickly, he shuts down and clams up. LH reflected, "Sometimes people just don't get you (truth of his distress)!" Nathan exclaimed, "Yes!" She continued, "When you turn away, get quiet, some people think you are being stubborn, but you're just getting your thoughts together (good intent and care)." Nathan responded, "You got it." When meeting with his mother, she learned that Nathan's grandmother was his primary care provider. LH also discovered that his mother avoided this self-disclosure up to this point for fear of being judged by the medical team as an unfit mother (truth of her distress). She was not a reliable informant about his after school eating and exercise habits, because she worked late most evenings. Longing to be seen as competent and involved, she offered well intended, but vague, hollow, frustrating responses to the team's questions (meaning behind her actions).

LH also attended to the patient-mother-medical team interactions. She made several crucial observations. One observation was that when entering the room, medical team members seemingly ignored Nathan's young adult developmental status. They bypassed him by directing questions about his daily life to his mother. LH inquired, "I noticed that your team talks mainly to your mother. What do you think about that?" Nathan expressed a preference to be seen as an adult, but he also wanted his mother to be viewed as important. The second observation was a

shift in the mother's demeanor when team members entered and exited the exam room. When present, she offered them clipped, terse responses. When absent, she engaged LH in a thoughtful give and take conversation, providing elaborated self-disclosing responses. LH again observed and then inquired, "I notice you become quiet when members of the team come in. Are you concerned about something?" She expressed her unease about the team's push to include Nathan's father. She believed that the father's ongoing overt avoidance and abdication of his parental role would further hurt Nathan (truth of her distress). Again, she did not express her opinion due to her fears of being judged as an uncooperative, unfit mother (underlying meaning of her actions).

Despite drawing the medical team's attention to this patient-family-team dynamic, LH found that they remained focused on Nathan's "defiance" and "manipulation" (e.g., "He gets her do things for him") and his mother's "lack of communication." Here, LH determined she had become effectively joined with Nathan and his mother and decided to move to stage two.

Stage 2: Reframe. After a careful assessment of the family's history, in stage two therapists work to discover with each participant a relational reframe of the presenting challenge. Relying on her/his position as leader for change, therapists steer participants away from the belief that "the patient is the problem." Building on research data to shape reframes, therapists might suggest "life's tragedies like chronic medical conditions influence how people think, feel, act, and respond." This "new" description rouses those locked in conflict to view themselves, one another, and their situation differently. Effective reframes help people see alternatives that garner hope, spark motivation, and inspire self-efficacy. ESFT directs mental health professionals to use reframes as the spring board for organizing change in system dynamics relative to four targets of assessment and change. In Nathan's case, LH planned to weave each

target into a reframe.

Executive functioning. Executive functioning signifies that family leaders (individuals, caregivers, spouses, or partners) organize and guide family members and their community of care to create a nurturing family environment. Effective family executives lead others through four key activities: boundary making, mutuality, praise, and value-based guidance. For example, an effective executive marks and preserves boundaries between subsystems and their community of care (i.e., make boundaries). *Boundaries* are rules that govern relationships. Some boundaries are clear and rigid (no hitting), and others are flexible and permeable (children influence parental decision making). *Mutuality* signifies a process wherein effective family leaders use their elevated position to empathically influence family members; it also implies that family members lower in the pecking order sway family leaders. Mutuality creates a family culture favoring emotional connection over blind obedience. *Praise* represents the family leader's strength-based focus, such that adaptive family functioning is expected, appreciated, and reinforced. *Value-based guidance* connotes how family leaders try to understand the belief systems of each family member, and when necessary, intervene via a clear set of principles and standards attached to the family's belief system and unique cultural values and standards. In stark contrast, ineffective executive functioning may range from a harsh leadership style to avoidance and abdication of responsibility. Ineffective leadership erodes a nurturing family environment. When this occurs, ESFT directs therapists to help family leaders and their community of care to build up executive functioning.

In Nathan's case and consistent with research suggesting that persons with a medical condition and their families appear more responsive to collaborative approaches, LH learned that Nathan wanted recognition from the medical team for his burgeoning adult status. This request

was critical because it established Nathan as a central player in his diabetes management. Although highlighting Nathan as an executive was an important therapeutic punctuation, his close relationships with his grandmother and mother suggested his openness and responsiveness to their influence through the next target, co-caregiver alliance.

Co-caregiver alliance. The co-caregiver alliance is the social support network that helps family executives build caring family contexts. Members of the alliance serve many functions, ranging from highlighting success through verbally praising family members for effective family functioning to monitoring potential breakdowns in leadership and relationships. Some co-caregiver alliances naturally and seamlessly help optimize family functioning. Others spark conflict within or between the executive subsystem and others (e.g., an adult patient and their physician). Persistent fighting between family members and members of their support system risks diluting family process leading to poor family functioning and harmful conditions. When this occurs, ESFT directs therapists to help the families and their community of care address these conflicts and the related breakdown in important relationships.

In Nathan's case, LH observed a key conflict in Nathan's co-caregiver alliance. In stark contrast with the medical team's conclusion, her emerging assessment suggested an effective co-caregiver alliance between Nathan, his mother, and his grandmother. She observed that Nathan, his family, and the medical team were locked into a core negative interactional pattern (CNIP) that led to a rupture in the family-medical team relationship. The medical team's push to include Nathan's father as a member of the co-caregiver alliance was driving a wedge in this critical connection. LH identified four vital tasks related to repairing this breach (understand how to form a new interactional pattern with the family). One task was to help team members appreciate how their push to recruit Nathan's father unintentionally and inadvertently fueled

unexpressed conflict and interpersonal withdraw. A second task was to help the medical team understand and appreciate Nathan's mother's less traditional role. The third task was to help Nathan's grandmother assume a more central position on the care team. Fourth and lastly, she needed to find a way to help the medical team join with Nathan and the family to foster their acceptance of the team's expertise and influence.

Attachment. Safe and secure attachments are the building blocks of a nurturing family environment. Individuals cope effectively when family members see beyond words and behavior to accurately "read" one another. This less hierarchical, more shared "I get you and you get me" experience helps family members weather and, at times, emotionally grow closer through adversity, tragedy, and trauma. When this does not occur, family members likely feel alone, isolated, and cut off from their inner psychological resources and others. Mental health professionals attending to research findings on these families know that relational problems before, during, and after the onset of chronic medical conditions can exacerbate maladaptive adjustment. ESFT directs therapists to help family members and their community of care strengthen attachments.

In Nathan's case, LH observed secure attachments between Nathan and his caregivers, but insecure attachments between the family and his medical team. Extrapolating from research showing that high family cohesion, emotional connection, and strong ties improve diabetes management outcomes, LH saw the key activity around this target as strengthening a connection between Nathan and his family with each medical team member, especially his nurse practitioner and endocrinologist. Should LH's therapeutic efforts in this area fall short of its intended mark, she developed a research informed alternative plan to directly assess how ever-present culture, and issues or power and privilege challenges may be driving a wedge in the minority family-

professional relationships.

Self-regulation. Optimal self-regulation also helps family leaders maintain a nurturing family environment. Well-regulated family members carry out four seemingly automatic but vital steps. They develop an anti-escalation style of relating (Omer, 2001); that is, they stop, look, listen, and then proceed when encountering intense feelings and conflicting perspectives. "Stop" illustrates that these responses are timed strategically. This "strike when the iron is cold" posture helps harness the responder's understandable but unwanted under- or over- reactivity leading to or stoking a conflict. "Look" demonstrates that well-regulated responses shun the demonization of others in favor of an unremitting search for the underlying good intent and care that resides in people and their actions (Alon & Omer, 2006). "Listen" highlights a "read between the lines" stance. Hearing the pleas of others to be valued, heard and accepted is crucial (Minuchin, 1993). Building on this anti-escalation approach, "proceed" shows how well-regulated responses set the stage for nurturing interpersonal exchanges and relationships. In stark contrast, poorly regulated responses are reactive, demonizing, and distancing. This venomous mix escalates conflicts and cements gridlock. When this occurs, ESFT directs mental health professionals to help family members and their community of care enhance self-regulation.

Because research indicates that relational conflict is related to poorer glycemic control, LH decided to promote self-regulation in two relational areas. One was to block Nathan's reactivity to and his mother's withdrawal from the nurse practitioner and endocrinologist. Another was to thwart the medical team's reactivity to and criticism of Nathan and his mother.

Create a reframe around the four targets of assessment and change. Constructing a reframe around the four critical targets of change, LH asked Nathan to "teach me about your

world" through an ecomap. She drew a house in the center of a piece of paper with concentric circles reaching out to the edge of the page. Nathan placed himself, his mother, grandmother, and two cats in the house (attachment). At this point, LH began the reframe. She observed, "You are your own man in this house (executive functioning), but your grandmother is your coach and mother is your assistant coach (co-caregiver alliance)" to which he agreed. An uncle and some friends were drawn in the circle outside of the house, and a minister was on the next circle out. Here, LH observed, "You want your team to come together around you (attachment)", and again he agreed. When asked where he would put his father in the support circles, he drew a figure on the table several inches away from the paper. When asked where the medical team could go in the support circles, Nathan drew his nurse practitioner and endocrinologist on the fourth circle outside of the house. At this point, LH repeated, "So what we learned is that you are your own man, but you've got coaches and a big team, too." Nathan's affirmative nod signaled the discovery of a reframe. At this point, LH was postured to use the reframe to build a new patient-family-medical team pattern. She stated, "Let's find a way to help this team to work together (self-regulation)!"

Stage 3: Enact. Stage three steers therapists to capitalize on spontaneous or planned enactments (scenarios) that activate family members and their co-caregiver alliance to experiment with new ways of relating. ESFT values enactments as opportunities for mental health professionals to use reframes to inspire/guide/direct participants to engage in interactions that promote collaboration and conflict resolution.

Nathan's father missed the third insulin administration class. At this point, Nathan became extremely agitated and disrespectful toward his nurse practitioner. She called LH to the room, expressed frustration, and then left. Nathan shared with LH that his father's broken

promises to attend reminded him of his abrupt cut off from his life when he came out as gay. The well-intended efforts by the medical team to include his father re-traumatized Nathan; the father's absences evoked the past experiences of abandonment. LH then asked Nathan whom he would like to have on his health team as an alternative, if his father was unable to attend. Nathan clearly stated that he needed his grandmother to be part of the plan, because she cooked his meals, managed family members' medications, and served as his strongest supporter. She then suggested that Nathan share this request with his nurse practitioner. Seeing an opening for an enactment, LH suggested and Nathan agreed to invite his nurse practitioner back into the room to study his ecomap. The enactment around the reframe afforded the opportunity for the nurse practitioner to experience Nathan as calm (self-regulation) and interested in assuming a leadership role (executive functioning), seeking relationships (attachment) leading to collaborative solutions (co-caregiver alliance) for his health care. The nurse practitioner listened attentively as Nathan described his ecomap including where he positioned her in the circles of support. LH asked him to share with the nurse practitioner where he located his father in the care team. Nathan put the picture on the floor in the exam room and walked out the door and into the hall. He stood there and said, "He's out here." This action-oriented scenario helped her see how Nathan clearly shared his thoughts and feelings through an alternative means of communication. Additionally, observing herself drawn on paper in the circles of support assisted her in appreciating that Nathan wanted her on his team (attachment, co-caregiver alliance). The "new" experience of Nathan inspired the nurse practitioner to ask, "What is the best way for me to invite your grandmother and maybe your uncle or a friend to join us for a planning meeting? Can we call them together?" Nathan decided to call his grandmother and mother.

Building on research demonstrating that collaborative team approaches are linked to

improved medical outcomes, LH next assembled Nathan, his grandmother, mother, and the medical team. Turning first to Nathan (executive functioning), she asked him to introduce his grandmother to the team. She then described the ecomap and repeated the reframe that Nathan is his own man with a coach and a team. The stage was set for another enactment. Nathan took the lead (executive functioning) and calmly (self-regulation) described what a week looks like in his home. His grandmother and mother offered affirming gestures and comments (co-caregiver alliance). The medical team listened quietly (self-regulation). Signaling to Nathan that "we got it," the team members suggested and the family considered how a state of the art insulin and nutrition plan might fit best into their lives (attachment).

With the family system understood and honored, Nathan, and his nurse practitioner offered invitations to his grandmother (co-caregiver alliance) to come to the clinic for an insulin class. LH was worried that his grandmother may be viewed in medical form parlance as an "other support individual," so it was vital for LH to help the medical team to embrace the grandmother's hierarchal position as Nathan's coach (reframe) and her central position (co-caregiver alliance). Perceived disrespect to the grandmother could potentially damage the burgeoning but tenuous patient-family-medical team attachment. Rather than the nurse practitioner entering as an expert, she agreed to a modified class structure that began with the mother and grandmother describing "a week in our life" to offer her a clearer picture of family structure and organization. Nathan was asked to chime in on each day of the week to fill in anything that was missing. Once the grandmother and mother were allowed to respectfully align as the "parents" of Nathan (co-caregiver alliance), a care plan evolved quickly. Nathan's grandmother was able to share the best ways that Nathan could learn about his illness and have daily schedules developed based on constraints imposed by Asperger's disorder. Both Nathan's

grandmother and mother learned about ways to better manage nutrition since his mother did the grocery shopping, and his grandmother did the cooking. It was also clarified that Nathan would typically spend the bulk of his day at his friend's house. The team decided to also invite Nathan's friend to participate in the diabetes education process (co-caregiver alliance).

Stage 4: Anchor. This stage guides mental health professionals to anchor changes in community based resources. By creating enactments which helped Nathan, his family, and the medical team experience one another in a more competent and nurturing way, LH helped the medical team shift from experts to collaborators. Responding well to the medical team's collaborative effort to offer expert input, Nathan was soon on a reduced insulin plan, and the whole family had adopted many new eating and exercise strategies that led to improvement in each of their overall health behaviors.

Conclusion

After reading this section, what does the therapist take to the next clinical encounter with a family facing a chronic medical issue? Regardless of their practice context, they likely see chronic medical issues and related psychosocial concerns as occurring in a complex social system. Because of this, they consider adopting a systemic, family centered, collaborative focus to work in the patient's and family system's best interest. This spotlight organizes them to construct a theoretically coherent, clinically relevant, and research informed treatment framework in which they believe.

This section illustrates how a mental health professional accomplished this imperative. She studied a research literature review and then created a research informed psychosocial practice for chronic medical issues checklist, which helped tether her therapeutic work to a research informed posture. She then selected a family therapy model that was congruent with

her personal belief system and world view. To shore her adherence to her selected clinical model, she used the ESFT checklist. The case study illustrated how she thoughtfully implemented translating research into clinical practice with a family representing a known vulnerable population. With these guidelines, suggestions, and examples, readers may consider how to apply this process to their own work with families and their communities of care confronting chronic medical issues.

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